

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-012953

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Filed District No. 316 Primary Registration District No. 3059 Registrar's No. 104

STATE FILE NUMBER

VS 300  
Rev. 4/59

1 0941

2 0941,2

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4 0

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9 049

10 45

11 094

12 90-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre,</b>		c. CITY OR TOWN <b>Bonne Terre,</b>	
Length of stay in lb <b>80 years</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>121 D. Street</b>		d. STREET ADDRESS (If outside, give location) <b>121 D. Street</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William John Whiteknight</b>		4. DATE OF DEATH <b>March 23, 1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/11/1870</b>
9. AGE (last birthday) <b>92</b>		10. IF UNDER 1 YEAR <b>10</b> Months <b>20</b> Days	
11. IF UNDER 24 HR <b>Hours</b> <b>Min.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad-Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad-Farm</b>	
11. BIRTHPLACE (City and state or country) <b>Cane Hill, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Perry Whiteknight</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Ann Fox</b>	
14. NAME OF HUSBAND OR WIFE <b>Annie Wagner Whiteknight</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT <b>Dorothy Whiteknight, Bonne Terre, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Degenerative Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Several</b> Years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Fractured Hip</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
20c. TIME OF INJURY <b>Hour</b> <b>Month, Day, Year</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Farmington, Missouri</b>	
20g. COUNTY <b>St. Francois</b>		20h. STATE <b>Mo.</b>	
21. I attended the deceased from <b>February 5, 1963</b> to <b>February 20, 1963</b> and last saw him alive on <b>Feb. 20, 1963</b>		Death occurred at <b>4:15 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>[Signature]</b> (Degree or title)		22b. ADDRESS <b>Farmington, Missouri</b>	
22c. DATE SIGNED <b>3-13-63</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>3/5/1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Francois Memorial Park, Bonne Terre, Rt. Mo.</b>	
23d. LOCATION (City, town, or county) <b>Bonne Terre, Mo.</b>		23e. STATE <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>Dale Sparks</b>		25. DATE RECD. BY LOCAL REG. <b>Mar. 13, 1963</b>	
26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		27. DATE <b>Mar. 13, 1963</b>	

(Licensed Embalmer's statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

*[Handwritten signature]*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer.

Signed Everett Sparks

Licensed Embalmer No. 4287

P. O. Address

Boone Linn  
Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.